

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/06/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155295</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C 06/03/2011</b>	
NAME OF PROVIDER OR SUPPLIER  <b>CLINTON HOUSE HEALTH AND REHAB CENTER</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>809 W FREEMAN ST FRANKFORT, IN 46041</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p><b>INITIAL COMMENTS</b></p> <p>This visit was a Post Survey Revisit (PSR) to the investigation of Complaints number IN00089779 and IN00089874 completed on 5/4/11.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the PSR 5/4/11 to the Recertification and State Licensure Survey completed on 3/25/11.</p> <p>Complaint number IN00089779 corrected Compliant number IN00089874 corrected</p> <p>Survey Date: June 3, 2011</p> <p>Facility number: 000192 Provider number: 155295 AIM number: 100291120</p> <p>Survey team: Toni Maley, B.S.W., T.C. Donna M Smith, R.N.</p> <p>Census bed type: SNF/NF: 63 Total: 63</p> <p>Census payor type: Medicare: 8 Medicaid: 44 Other: 11 Total: 63</p> <p>Sample: 5</p> <p>Clinton House Health and Rehab Center was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2 in regard to the PSR</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 000}	Continued From page 1 to Complaints number IN00089779 and IN00089874.  Quality review completed 6-3-11 Cathy Emswiller RN			{F 000}			